44.5.4.6.1 The rate of interest charged by the municipality is less than the interest which a prudent borrower would have had to pay in the money market existing at the time the loan was made;

44.5.4.6.2 The payment of property taxes is deferred under an arrangement acceptable to the municipality;

44.5.4.6.3 The late payment of property taxes results from the financial needs of the provider and does not result in excess funds; and

44.5.4.6.4 Approval in writing has been given by the Department prior to the time period in which the interest is incurred. Any requests for prior approval must be received by the Department at least two weeks prior to the desired effective date of the approval.

44.5.4.7 Limitation on the participation of capital expenditures. Interest is not allowable with respect to any capital expenditure in plant and property, and equipment related to patient care, which did not receive a required Certificate of Need Review approval.

44.5.5 The Department will make adjustments to the nursing facility's fixed cost component of the per diem rate to reflect the effect of refinancing which results in lower interest payments.

44.6 Return on Equity Capital of Proprietary Providers

44.6.1 Principle. A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The amount on an annual basis is eight percent (8%).

44.6.2 For purposes of this subpart, the term "propriety providers" means providers, whether sole proprietorships, partnerships or corporations organized and operated with the expectation of earning profits for the owners, as distinguished from providers organized and operated on a non-profit basis.

44.6.3 For the purpose of computing the allowable return, the provider's equity capital means:

44.6.3.1 The provider's investment in plant and property and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net or noncurrent debt related to such investment or deposited funds) and,

44.6.3.2 Net working capital maintained for necessary and proper operation of patient care activities.

44.6.3.3 Notwithstanding anything in Subsection 44.6.3.1 and 44.6.3.2 debt representing loans from partners, stockholders, or related organizations, on which interest payments would be allowable as costs but for Subsection 44.5.4.1 is included in computing the amount of equity capital in order that

the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost.

44.6.4 Acquisitions. For facilities or tangible assets acquired, the excess of the purchase price paid for a facility or assets over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible asset, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital.

44.6.5 Computation of return on equity capital. For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

44.6.6 Unapproved capital expenditures. With respect to any capital expenditure, a provider's investment in plant, property and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care which are found to be expenditures which have not been submitted to the designated planning agency as required, or have been determined to be inconsistent with health facility planning requirements, are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

44.6.7 Exclusion from Computation of Average Equity Capital. For the purpose of computing average equity capital, the following are examples of items not to be included in the computation:

44.6.7.1 Notes and loans receivable from owners or related organizations.
44.6.7.2 Goodwill.
44.6.7.3 Unpaid capital surplus.
44.6.7.4 Treasury Stock.
44.6.7.5 Unrealized capital appreciation surplus.
44.6.7.6 Cash surrender value of life insurance policies.
44.6.7.7 Prepaid premiums on life insurance policies.
44.6.7.8 Assets acquired in anticipation of expansion and not presently used in the provider's operation or in the maintenance of patient care activities during the rate period.
44.6.7.9 Inter-company accounts.
44.6.7.10 The portion of the value of any motor vehicle that is attributed to personal use.
44.6.7.11 Any other assets not directly related to or necessary for the provision of patient care to publicly-aided patients.
44.6.7.12 Funded Depreciation.
44.6.7.13 Accrued interest on related party loans and cash invested in money market accounts or savings accounts for a period of over six months.

44.7 Worker's Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine for facility fiscal years that began on or after October 1, 1992, and deductibles paid by facilities related to such cost are allowable fixed costs. Estimated amounts for workers compensation insurance audit premiums will not be accepted as an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of worker's compensation insurance. In those instances where the Department finds that a facility pays more than the usual and customary rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under Medicaid. Allowable costs are subject to an experience modifier of 1.4; that is, cost associated with an experience modifier of 1.4 or under are allowable. Workers compensation costs incurred above the experience modifier of 1.4 shall be considered unallowable and will be settled at time of audit.

44.7.1 The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $40.00 per covered employee per year for nursing facilities with an experience modifier greater than .9. The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $70.00 per covered employee per year for nursing facilities with an experience modifier equal to or less than .9. Allowable costs shall include the cost of educational programs and training classes, transportation to and from those classes, lodging when necessary to attend the classes, materials needed in the preparation and presentation of the classes (when held at the nursing facility), and equipment (e.g.: lifts) which lead towards accomplishing the established goals and objectives of the facility's safety program. Non-allowable costs include salaries paid to individuals attending the safety classes and personal gifts such as bonuses, free passes to events or meals, and gift baskets.

44.7.2 The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 Administrator in Training. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of Human Services recovering 100% of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, 100% of the amount allowed will be recovered by the Department.

44.9 Acquisition Costs. Fifty percent of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion (at least 50%) of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition. This acquisition cost will not include any fees (eg: accounting, legal) associated with the acquisition.

44.10 Occupancy Adjustment. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). The 90% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/95, and shall be cost settled at the time of audit. For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period. To the extent that fixed costs are allowable, such cost will be adjusted for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

50 PUBLIC HEARING

The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

70 SPECIAL SERVICE ALLOWANCE

70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility.

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific patient. This type of service is limited to professional services such as physical therapy, occupational therapy, and

speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)

OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

80.1 Principle. For facility fiscal years beginning on or after July 1, 1995 the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year that begins on or after October 1, 1992, as determined from the audited cost report (or as filed cost report until an audit is completed) will be the basis for the base year computations (subject to upper limits).

The base year direct, indirect and routine patient care cost component costs will be trended forward using the inflationary factors from the table "HCFA Nursing Home Without Capital Market Basket" from the publication Health Care Costs published by DRI/McGraw-Hill as described in Section 91. Inflation factor data for salaries will be acquired from the Maine Health Care Facility Economic Trend Factor. The inflation factors will be based on the most recent DRI publications available at the times the rates are determined. Beginning October 1, 1993 the determination of the direct care cost component of each facility's base year rate will be computed by calculating the facility's case mix adjusted cost per day pursuant to Section 80.3. The 1992 (fiscal year beginning on or after 10/1/92) base year indirect component costs, will be used to compute the median costs, upper limits and incentive payments that will be the basis for computing each facility's rate. The 1992 fiscal year (beginning on or after 10/1/92) routine care component costs, adjusted for the 1993 statewide average accounting fees, will be the basis for computing the median routine care component costs and upper limits that will be the basis for computing each facility's rate. The nursing facility's direct, indirect and routine cost components allowable rate will be inflated to the end of the nursing facilities current fiscal year. The prospective rate shall consist of four components : the direct patient care cost component as defined in Section 41; the indirect patient care cost component as defined in Section 42, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

80.2 FIXED COST COMPONENT

The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the

remaining months of their initial operating periods. To the extent that fixed costs are allowable, such cost will be adjusted for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

80.3 DIRECT PATIENT CARE COST COMPONENT

80.3.1 Case Mix Reimbursement System

80.3.1.1 The direct resident care cost component utilizes a case mix reimbursement system. Case mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(a) the assessment of residents on the Department's approved form - MDS as specified in Section 41.2.;

(b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Section 80.3.2.;

(c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index.

80.3.2 Case mix resident classification groups and weights

There are a total of 45 case mix resident classification groups, including one resident classification group used when residents can not be classified into one of the 44 clinical classification groups.

Each case mix classification group has a specific case mix weight as follows:

RESIDENT CLASSIFICATION GROUP	CASE MIX WEIGHT
REHABILITATION	
REHAB VERY HI/ADL 14-18	2.171
REHAB VERY HI/ADL 8-13	1.605
REHAB VERY HI/ADL 4-7	1.427
REHAB HI/ADL 15-18	2.022
REHAB HI/ADL 12-14	1.623
REHAB HI/ADL 8-11	1.491
REHAB HI/ADL 4-7	1.350

REHAB MED/ADL 16-18	1.886
REHAB MED/ADL 8-15	1.426
REHAB MED/ADL 4-7	1.337
REHAB LOW/ADL 12-18	1.350
REHAB LOW/ADL 4-11	1.202
EXTENSIVE	
EXTENSIVE 3/ADL 7-18	3.968
EXTENSIVE 2/ADL 7-18	2.424
EXTENSIVE 1/ADL 7-18	1.673
SPECIAL CARE	
SPECIAL CARE/ADL 17-18	1.534
SPECIAL CARE/ADL 14-16	1.375
SPECIAL CARE/ADL 7-13	1.279
CLINICALLY COMPLEX	
CLIN. COMP W/DEP/ADL 17-18	1.356
CLIN. COMP ADL 17-18	1.323
CLIN. COMP W/DEP/ADL 11-16	1.193
CLIN. COMP/ADL 11-16	1.128
CLIN. COMP W/DEP/ADL 6-10	1.127
CLIN. COMP/ADL 6-10	0.996
CLIN. COMP W/DEP/ADL 4-5	0.958
CLIN. COMP/ADL 4-5	0.799
IMPAIRED COGNITION	
COG. IMPAIR W/RN REHAB/ADL 6-10	1.021
COG. IMPAIR/ADL 6-10	0.919
COG. IMPAIR W/RN REHAB/ADL 4-5	0.794
COG. IMPAIR/ADL 4-5	0.688
BEHAVIOR PROBLEMS	
BEHAVE PROB W/RN REHAB/ADL 6-10	1.021
BEHAVE PROB/ADL 6-10	0.900
BEHAVE PROB W/RN REHAB/ADL 4-5	0.715
BEHAVE PROB/ADL 4-5	0.610

Approval Date: _____ Effective Date: _____

PHYSICAL FUNCTIONS	
PHYSICAL W/RN REHAB/ADL 16-18	1.145
PHYSICAL/ADL 16-18	1.099
PHYSICAL W/RN REHAB/ADL 11-15	1.076
PHYSICAL/ADL 11-15	1.008
PHYSICAL W/RN REHAB/ADL 9-10	0.918
PHYSICAL/ADL 9-10	0.896
PHYSICAL W/RN REHAB/ADL 6-8	0.807
PHYSICAL/ADL 6-8	0.716
PHYSICAL W/RN REHAB/ADL 4-5	0.686
PHYSICAL ADL 4-5	0.563
UNCLASSIFIED	0.563

80.3.3 Base Year Direct Resident Care Cost Component

80.3.3.1 Source of base year cost data. The source for the direct resident care cost component of the base year cost data is the audited cost report (as filed cost report until an audit is completed) for the nursing facilities fiscal year beginning on or after October 1, 1992. At the point of time that audited report data is available for the base year, the nursing facility rate for subsequent quarters will be based on those figures. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

80.3.3.2 Case Mix Index

The Bureau of Medical Services shall compute each facility's case mix index for the base year as follows:

(a) For each facility the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of March 31, 1993.

(b) For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group excluding the residents in the unclassified group by the case mix weight for the relevant classification group.

(c) The sum of these products divided by the total number of Medicaid residents excluding the residents in the unclassified group equals the facility's case mix index.

80.3.3.3 Base year case mix adjusted Medicaid cost per day

Each facility's direct resident care case mix adjusted cost per day will be calculated as follows:

(a) The facility's direct resident care cost per day, as specified in Section 80.3.3.1, is divided by the facility's base year case mix index to yield the case mix adjusted cost per day.

80.3.3.4 Array of the base year case mix adjusted cost per day.

For each peer group, the Bureau shall array all nursing facilities case mix adjusted costs per day inflated to June 30, 1995 from high to low and identify the median.

Facilities that have level A deficiencies cited by the Division of Licensing and Certification in the base year are excluded from the array for purposes of identifying the median.

80.3.3.5 Limits on the base year case mix adjusted cost per day.

The upper limit on the base year case mix adjusted cost per day shall be the median plus fifteen per cent (15%). The upper limit on the base year case mix adjusted cost per day shall be the median plus twelve per cent (12%) for the facilities fiscal year that begins on or after July 1, 1995.

80.3.3.6 Each facility's case mix direct care rate shall be the lesser of the limit in Section 80.3.3.5. or the facility's base year case mix adjusted cost per day.

80.3.4 Quarterly Calculation of the Direct Resident Care Component

The Bureau of Medical Services shall compute the direct resident care cost component for each facility on a quarterly basis.

80.3.4.1 Calculation of the case mix index.

The Bureau of Medical Services shall compute each facility's case mix index for the rate period as follows:

For each facility the number of Medicaid residents in each case mix classification group shall be determined from the assessment date on the MDS on all Medicaid residents in the facility as of the 15th day of the prior quarter (e.g. For a October 1 rate, the facility's case mix index would be computed using the most recent assessments of Medicaid residents with an assessment date of June 15.)

For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group including those in the unclassified group by the case mix weight for the relevant classification group. The sum of these products divided by the total number of Medicaid residents equals the facility's case mix index. The roster sent to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing facilities

responsibility to check the roster and make corrections within one week of receiving the roster and submit such corrections to the Department or it's designee.

For purposes of this section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For Medicaid residents, the facility would be paid the facility rate for the number of days the resident is at the facility.)

80.3.4.2 Direct resident care rate per day

The direct resident care rate per day shall be computed by multiplying the allowable base year case mix adjusted cost per day by the applicable case mix index.

80.3.4.3 The direct cost, as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct patient care costs (subject to the limitations cited in Section 41) from the base year by the inflationary factor defined in Section 91.

80.3.5 Direct Patient Care Cost Savings. Managers of facilities who operate in an efficient and economical manner and thereby limit their direct patient care costs during their fiscal year to less than the amounts paid through the direct patient care cost component of the final prospective rate will share with the Department in the resulting savings the resulting savings.

For fiscal years beginning on or after July 1, 1995 direct patient care cost savings will result in the facility retaining 25% of this savings as long as residents needs are determined to be met and the facilities comply with all relevant state and federal requirements.
Facilities which incur direct patient care costs during their fiscal year in excess of the direct patient care cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.4 INDIRECT PATIENT CARE COST COMPONENT

Indirect Care Patient Care Cost component base year rates shall be computed as follows:

80.4.1 Using each facility's base year (fiscal year beginning on or after 10/1/92) cost report, the provider's base year total allowable Indirect Patient Care costs shall be determined in accordance with Section 42.

80.4.2 The base year per diem allowable Indirect Patient Care costs for each facility shall be calculated by dividing the base year total allowable indirect patient care costs by the total base year resident days.

80.4.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable Indirect Patient Care costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.